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2.4430 continued

Analysis

The relative weight of .6881 in this example means that this DRG is less expensive to treat than the average DRG (with a weight of 1.0000). In other words, it indicates this DRG costs 31.19% less in relation to average DRGs.

2.4440 Modification of Relative Weights for Low-Volume DRGs

If very few paid claims are available for a DRG, any one claim can have a significant effect on that DRG's relative weight, day outlier limit, cost outlier limit, and daily rate. A statistical methodology was used to determine the minimum sample size required to set a stable weight for each DRG, given the observed sample standard deviation. For DRG's lacking sufficient volume in the Kansas Medicaid/Medikan claims data base, the DRG weight was derived using an external data base, with preference given to DRG weights derived from populations expected to be similar to the Kansas Medicaid/Medikan population. ~~Sources used were Oregon Medicaid DRG weights, State of Oregon All Payor DRG relative weights, and Federal Medicare DRG weights. All externally derived DRG weights were calculated using the same version of the Grouper as was used in calculating DRG relative weights from the Kansas Medicaid data base.~~ Sources used were an average of four states all payer data from 1994 from Kansas, Iowa, Illinois, and Wisconsin, and HCFA Medicare weights where other alternatives were not sufficient.

Outlier thresholds and average length of stay statistics for DRG's with externally derived weights were set using the appropriate statistics from the same external source. For DRG's whose weights were derived from Federal Medicare weights, in which case published cost outlier thresholds are based on a substantially different formula than is used by Kansas Medicaid, a least-squares regression equation was used to estimate the outlier threshold, based on the DRG weight.

2.4450 Modification of Relative Weights for Selected DRG Pairs

In cases of DRG "pairs" - one DRG with complications and comorbidity (CC's) and the other DRG without CC's - if the DRG without CC's was weighted higher than the DRG with CC's, the relative weights of both DRG's were replaced with the weighted average of the two relative weights.

2.4500 Group Payment Rates

The Kansas Department of Social and Rehabilitation Services determined group payment rates for the three general hospital groups discussed in section 2.3000. The group payment rates are used in conjunction with DRG relative weights and other components developed for the Kansas DRG reimbursement system to determine payment.

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2.4510 Determination of Group Payment Rates

The same adjusted data base as used for DRG weights (subsection 2.4420) was used for developing group rates. Claims were identified by hospital and then sorted by the three groups based on the hospital assignments to groups. All claims were thus divided into three groups.

In order to adjust unaudited cost reports for the effect of Medicare audits, an audit adjustment factor was determined. This was done by comparing the cost of Kansas Medicaid/MediKan services from the preliminary ~~1993 and 1994~~ 1995 cost reports with the Medicare audited cost reports for the same year which were available as of ~~July, 1996~~ December, 1997. This adjustment was averaged for all hospitals to determine the audit adjustment factor to be applied to each group rate.

Audit Settlement Comparison
Cost Data for the Fiscal Year ending 12/31/95

Routine Services	Days	Charges	Unaudited Ratio	Audited Ratio	Unaudited Cost	Audited Cost
Routine	151	27,740	219.36	218.45	33,123	32,986
Psychiatric	0	0	219.36	218.45	0	0
Detox	0	0	219.36	218.45	0	0
ICU	0	0	219.36	218.45	0	0
CCU	5	1,875	219.36	218.45	1,097	1,092
Nursery	44	6,515	188.64	187.72	8,300	8,260
Subtotal - Routine	200	36,130			42,520	42,338

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2.4510 continued

Ancillary Services					
Operating Room	2,992	0.832623	0.827636	2,491	2,476
Recovery Room	150	0.832623	0.827636	125	124
Delivery Room	5,291	1.624450	1.600224	8,595	8,467
Anesthesiology	1,547	0.338158	0.338382	523	523
Radiology-Diagnostic	2,100	0.820164	0.819799	1,722	1,722
Radiology-Therapeutic	0	0.820164	0.819799	0	0
Nuclear Medicine	0	0.820164	0.819799	0	0
Laboratory	7,495	0.635778	0.635706	4,765	4,765
Blood	80	0.513977	0.514555	41	41
Respiratory Therapy	4,495	0.436028	0.435172	1,960	1,956
Physical Therapy	28	0.791218	0.787545	22	22
Occupational Therapy	0	0.803771	0.801252	0	0
Speech Therapy	0	0.803771	0.801252	0	0
EKG	635	0.315497	0.315743	200	200
EEG	0	0.315497	0.315743	0	0
Medical Supply	3,450	0.348991	0.348657	1,204	1,203
Drugs	7,775	0.600985	0.601254	4,672	4,675
Ultrasound	270	0.095519	0.325114	26	88
Emergency	755	2.229117	2.219673	1,683	1,676
Other Charges	0			0	0
Subtotal - Ancillary	37,063			28,053	27,960
Total	73,193			70,574	70,298

Percent Change due to Audited Cost Report 0.39

For each group, total cost adjusted for the effect of audits, total DRG weight (using the weights computed for the DRGs assigned to the various claims), and total number of claims were determined. Using these totals, the average cost and average DRG weight were computed for each group. Next, the average cost divided by the average DRG weight gave the payment rate for each hospital group.

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2.4520 Example of Group Rate Computation

The following is a highly simplified example which, while illustrating the methodology used, does not represent actual numbers.

Data

Group 1		Group 2		Group 3	
DRG Cost	DRG Weight	DRG Cost	DRG Weight	DRG Cost	DRG Weight
$1,500	.5000	$1,200	.5000	$1,000	.5000
2,000	.8000	2,000	1.0000	2,000	1.0000
2,500	1.0000	800	.4000	600	.6000
3,000	1.2000	2,500	1.3000		
4,000	1.5000	3,000	1.4000		
1,000	.4000	5,000	1.8000		
6,000	2.2000	1,600	.7400		
4,500	1.4000				
2,500	1.0000				
2,000	.9000				

Computations	Group 1	Group 2	Group 3
Total Cost of Claims	$ 29,000	$16,100	$ 3,600
Total DRG Weight	10.9000	7.1400	2.1000
Total Number of Claims	10	7	3
Average Cost	$ 2,900	$ 2,300	$ 1,200
Average DRG Weight	1.0900	1.0200	.7000
Group Payment Rate	$ 2,660.55	$ 2,254.90	$ 1,714.29

The group payment rate was computed by dividing the average cost by the average DRG weight.

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2.4530 Medical Education Addition to Rates

For hospitals with medical education costs, the group payment rates were modified as follows:

$$\text{Hospital Specific Rate} = \text{Group Payment Rate} + \text{Hospital Specific Medical Education Rate}$$

The hospital specific medical education rate has two components, direct medical education (DME) rate and indirect medical education (IME) rate. These were computed as follows:

$$\text{Direct Medical Education Percent} = \frac{\text{Total Direct Medical Education Cost}}{\text{Total Cost for the Hospital}}$$

$$\text{Indirect Medical Education Percent} = 1.89 \times ((1 + \text{ratio})^{0.405} - 1)$$

$$\text{Hosp. Specific Medical Education Rate} = \text{Group rate} \times (1 + \text{DME Percent} + \text{IME Percent})$$

2.4600 DRG Daily Rates

The Department computed DRG daily rates for all DRG classifications. These rates will be used for computing reimbursement in cases involving day outliers, transfers, and eligibility changes (see subsections 2.5300, 2.5400, and 2.5600).

2.4700 Hospital Specific Medicaid Cost to Charge Ratios

The Department established a cost to charge ratio of Medicaid utilization of inpatient services for each hospital. This ratio shows a comparison of Medicaid reimbursable costs of general hospital inpatient services with the corresponding covered charges.

Cost to charge ratios (CCR's) were calculated using the cost reports submitted by hospitals and charge data from the claims database used to compute the DRG weights and hospital group rates.

These ratios will be used in the DRG reimbursement system to estimate costs of claims for determining whether the claims meet the cost outlier criteria (subsection 2.5110), and also to compute payment for cost outliers (subsection 2.5310). Please note these ratios should not be confused with the cost to charge ratios of various ancillary service departments computed in hospital cost reports.

2.5000 Determination of Payment Under the DRG Reimbursement System

This section provides policies and methodologies for the determination of payment in various situations under the DRG reimbursement system.

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2.5100 Identification of Outlier Claims

Each claim that is eligible for an outlier payment, will be tested to determine whether it meets the cost and/or day outlier criteria. If the claim does not qualify as either a cost or a day outlier, the standard DRG payment will be made to the hospital, unless the claim falls under one of the categories discussed in subsections 2.5400 through 2.5720 and another method is used for computing payment.

2.5110 Testing for Cost Outlier

The covered charges on the claim will be multiplied by the pre-established Medicaid cost to charge ratio for the hospital (subsection 2.4700) to estimate the cost of the claim. If the estimated cost is higher than the cost outlier limit established for the DRG which has been assigned to the claim, a cost outlier payment will be made to the hospital in addition to the standard DRG amount.

2.5120 Testing for Day Outlier

If the covered length of stay on the claim is higher than the day outlier limit established for the DRG that has been assigned to the claim, a day outlier payment will be made to the hospital in addition to the standard DRG amount.

2.5130 Example of Testing for Outlier

Data

Hospital Data:	Group Payment Rate	$ 2,836
	Cost to Charge Ratio	.78
Claim Data:	Covered Charges	$39,760
	Covered Length of Stay	50 days
DRG Data:	DRG Weight	4.2294
	Cost Outlier Limit	$32,899
	Day Outlier Limit	67 days
	Daily Rate	$ 503
	Adjustment Percentage	.75

Computation/Comparison

Testing for Cost Outlier:

Estimated Cost of Claim	=	Covered Charges x Ratio	
	=	$39,760	x .78
	=	$31,013	

Compare With Cost Outlier Limit $32,899

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Section 2.5130 continued

Testing for Day Outlier:

Covered Length of Stay	50 days
Compare With Day Outlier Limit	67 days

Analysis

Cost Outlier: The estimated cost of the claim ($31,013) is less than the cost outlier limit ($32,899). Therefore, the claim is not a cost outlier.

Day Outlier: The covered length of stay on the claim (50 days) is less than the day outlier limit (67 days). Therefore, the claim is not a day outlier.

2.5200 Standard DRG Payment

Standard DRG amount will constitute the base payment for an inpatient discharge except in those situations where a partial payment may be made. Any outlier payment for the qualifying claims will be in addition to the standard DRG payment.

Standard DRG amount for a claim can be obtained by multiplying the relative weight of the DRG assigned to the claim, by the group payment rate assigned to the hospital.

Example of Standard DRG Payment Calculation:

Referring to the data in subsection 2.5130:
Standard DRG Payment = DRG Weight x Hospital Group Payment Rate

= 4.2294 x $ 2,836
= $11,995

2.5300 Payment for Outlier Claims

If a covered general hospital inpatient stay is determined to be a cost or day outlier, the total reimbursement will consist of the standard DRG payment plus an additional amount for the outlier portion of the claim.

2.5310 Cost Outlier Payment

The payment for the cost outlier portion of a claim will be obtained by multiplying the difference between the estimated cost of the claim and the applicable cost outlier limit, by the DRG adjustment percentage. Cost outlier payment will be made for up to 360 inpatient days of stay, beyond which only day outlier payment will be made.

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2.5310 continued

Example of Computing Cost Outlier Payment:

Data

Hospital Data : Same as subsection 2.5130
Claim Data : Covered Charges....$45,980
DRG Data : Same as subsection 2.5130
Standard DRG Payment: $11,995 (from subsection 2.5200)
Assumption : Not a day outlier

Computations

Estimated Cost = Covered Charges x Hospital Ratio
= $45,980 x .78
= $35,864

Payment for Cost Outlier Portion = (Estimated Cost - Cost Outlier Limit) x DRG Adj. Percentage
= ($35,864 - $32,899) x .75
= $ 2,224

Total Payment = Std. DRG Pymt. + Outlier Pymt.
= $11,995 + $2,224
= $14,219

2.5320 Day Outlier Payment

The payment for the day outlier portion will be obtained by multiplying the difference between the covered length of stay and the applicable day outlier limit, by the DRG daily rate and the DRG adjustment percentage.

Example of Day Outlier Payment Computation:

Data

Hospital Data : Same as subsection 2.5130
Claim Data : Covered Length of Stay.....73 days
DRG Data : Same as subsection 2.5130
Standard DRG Payment: $11,995 (from subsection 2.5200)
Assumption : Not a cost outlier

Computations

Payment for Day Outlier Portion = [Covered Length of Stay - Day Outlier Limit] x DRG Daily Rate x DRG Adjustment Percentage
= (73 - 67) x $503 x .75
= $2,264

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Section 2.5320 continued

Total Claim Payment	= Standard DRG Payment	+	Outlier Payment
	= $11,995	+	$2,264
	= $14,259		

2.5330 Simultaneous Cost and Day Outlier Payment

If a covered general hospital inpatient stay is determined to be both a cost outlier and a day outlier, the reimbursement will be the greater of the amounts computed for cost outlier and day outlier.

Example of Payment for Simultaneous Cost and Day Outlier:

Data

Total Claim Payment for Cost Outlier...$14,219 (subsection 2.5310)
Total Claim Payment for Day Outlier....$14,259 (subsection 2.5320)

Analysis

The higher of the two amounts, $14,259, will be the reimbursement amount for the claim which meets both cost outlier and day outlier criteria.

2.5400 Payment for Transfers

When a recipient is transferred during a covered general hospital inpatient stay from one hospital to another hospital, the reimbursement to all hospitals involved in the transfer(s) will be computed as follows.

2.5410 Transferring Hospital(s)

The reimbursement to each transferring general hospital shall be the DRG daily rate for each covered day of stay. Total payment to each transferring hospital shall be no greater than the standard DRG amount, except where the transferring hospital is eligible for outlier payments.

2.5420 Discharging Hospital

The discharging general hospital shall be reimbursed the standard DRG amount. If the claim qualifies as an outlier, the discharging hospital shall be eligible for an outlier payment based solely on the length of stay at the discharging hospital.

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2.5430 Transfer To or From a State Operated Hospital

If the transferring hospital or the discharging hospital is a state operated hospital, reimbursement to the state operated hospital will be computed according to the methodology for state operated hospitals.

2.5440 Example of Payment Determination in Transfers

The following situation will provide an illustration of the various payment methods used when a patient is transferred from one hospital to another. Although the situation may not be realistic with regard to the medical treatment provided, it shows all basic payment methods for patient transfers through a single example.

A patient is admitted to a state operated hospital (Hospital A), and after a stay of two days with $1,400 in billed charges, the patient is transferred to a general hospital (Hospital B). Hospital B has the patient for three days and the case is assigned DRG #186. Hospital B is in Group 2. The patient is then transferred to another general hospital (Hospital C) due to complications. The patient is discharged after six days from Hospital C, and is assigned DRG #186. Hospital C is in Group 1.

Payment to Hospital A: Since Hospital A is a state operated hospital, the payment will be determined using the methodology specified in the section on state operated hospitals.

Payment to Hospital B: Hospital B is a transferring general hospital, and will therefore be paid a DRG daily rate for each day of stay, with total payment limited by the standard DRG amount.

Data Used for this example:

DRG Daily Rate	$ 597
DRG Weight	.6515
Group 2 Rate	$2307

The transfer payment will be computed by multiplying the number of days times the DRG daily rate; i.e., 3 times $597, or $1,791. This amount will be compared against the standard DRG amount, and the lesser of the two shall be paid. The standard DRG amount is .6515 times $2,307, or $1,503. Therefore, Hospital B would be paid $1,503.

Payment to Hospital C: Hospital C is a discharging general hospital, and would therefore be paid the standard DRG amount plus any outlier payment, if applicable.

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Section 2.5440 continued

Data Used for this example:

DRG Weight	.6515
Group 1 Rate	$2836

The standard DRG amount is $1,847.65. If this claim had been a day and/or a cost outlier, an additional payment would be made.

2.5500 Payment for Readmissions

2.5510 Readmission to the Same Hospital

If a recipient is readmitted to the same hospital within 30 days of discharge, and if the readmission is determined to have resulted from an inappropriate discharge; the reimbursement will be made only for the first admission.

2.5520 Readmission to a Different Hospital

If a recipient is readmitted to a different hospital within 30 days of discharge, and if the readmission is determined to have resulted from an inappropriate discharge; payment will be made only to the second hospital to which the patient was readmitted. Payment made to the first hospital for the original (first) admission will be recouped.

2.5530 Determination of Payment for Readmissions

Whether the reimbursement should be made for the first or the second admission (i.e., the original admission or the subsequent readmission), will be ruled by the discussion in the preceding subsections 2.5510 and 2.5520. The amount of reimbursement in each situation will be determined as provided in subsections 2.5100 through 2.5400.

2.5540 Federal Fiscal Year End Proration

The reimbursement for inpatient stays through Sept. 30 shall be computed using the DRG system components (group payment rates, outlier limits, DRG weights, etc.) in effect during that period. For services provided on and after Oct. 1 the payment amount computations shall use the system components effective Oct. 1.

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2.5600 Recipient Eligibility Changes

If a recipient is determined ineligible for the Medicaid/MediKan Program for a portion of the inpatient stay, reimbursement shall be made to the general hospital only for those days of stay which were also days of eligibility. No reimbursement shall be made for services provided on days when a recipient was ineligible for the Medicaid/MediKan Program.

The payment amount will consist of the DRG daily rate for each eligible day during the inpatient stay in the hospital. No more than the standard DRG payment plus any outlier payment (if applicable), will be allowed as the total payment. Only the Medicaid covered inpatient days and charges will be used for outlier payment computation.

2.5700 Payment for Interim Billings

Hospitals will be allowed to submit interim bills for inpatient stays longer than 180 days. Each interim bill must cover 180 or more continuous days of service except the discharge billing and the federal fiscal year end cut-off billing, each of which may include less than 180 days as the situation may be.

2.5710 Payment for First Interim Billing

The first interim bill will be treated like any other claim, in the sense that it will be tested to determine if it meets the cost and/or day outlier criteria. If the stay covered in the first interim bill does not qualify as an outlier, only the standard DRG amount would be paid. If the claim exceeds the cost and/or day outlier limit(s), an appropriate outlier payment will be made in addition to the base amount.

2.5720 Payment for Second and Subsequent Interim Billings

At the time of each interim bill after the first, an outlier payment amount will be determined using the cumulative cost and days since the date of admission through the last service date included in the current interim billing. One of the following two situations may occur:

Up to 360 Days: Up until 360 days of continuous stay, the Department will authorize the fiscal agent to pay the higher of cost and day outlier amounts for each interim bill.

Longer than 360 Days: When the stay becomes longer than 360 days, only day outlier payments will be made.

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2.6000 Settlements and Recoupments

There shall be no year end settlements under the DRG reimbursement system. However, some settlements and recoupments may occur because of Surveillance/Utilization Review or other reviews which determine that payments were in error.

3.0000 General Hospital Reimbursement for Inpatient Services Excluded from the DRG Reimbursement System

Reimbursement for heart, liver and bone marrow transplant services shall be excluded from the DRG payment system. Reimbursement for these transplants shall be based upon the lesser of reasonable costs or customary charges, contingent upon transplant surgery. An annual settlement shall be made. For services provided prior to the transplant surgery, or if transplant surgery is not performed, reimbursement shall be made according to the DRG payment system.

4.0000 Reimbursement for Inpatient Services in State Operated Hospitals

Reimbursement for inpatient services in special hospitals shall be based upon the lesser of reasonable costs or customary charges for covered services rendered to eligible individuals.

4.1000 Hospital Changing From a General to a Special Hospital

If a hospital changes from a general to a state operated hospital, claims shall be paid as shown below.

a) Patients admitted prior to the effective date of becoming a state operated hospital shall be paid as a general hospital.

b) Patients admitted on or after the effective date of becoming a state operated hospital shall be paid as a state operated hospital.

4.2000 Malpractice Costs in a State Operated Hospital

Medicaid malpractice cost shall be determined by dividing the risk portion of malpractice cost by total hospital charges and multiplying the result by allowable Medicaid charges. This shall be used for all cost report periods ending on and after 7/1/91.

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5.0000 Reimbursement for NF Services (Swing Beds) in General Hospitals

Reimbursement for NF services (swing beds) provided in general hospitals (swing bed hospitals) shall be pursuant to 42 CFR 447.280.

6.0000 Disproportionate Share Payment Adjustment

The Medical Assistance Program (Medicaid/MediKan) of the State of Kansas shall make a reimbursement adjustment for disproportionate share hospitals. The reimbursement adjustment for disproportionate share hospitals shall be made for hospitals eligible under either criteria contained in 6.1000 or 6.2000 below.

Hospitals to be eligible under either Option 1 or Option 2 must have at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under the State Plan, except where the hospital serves predominantly individuals under 18 years of age, or where nonemergency obstetric services to the general population were not offered as of July 1, 1988. In rural areas the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. Please see section 6.50000 for addition instructions.

6.1000 Option 1

If determined eligible for disproportionate share payment adjustment according to P.L. 100-203, Section 4112, Subsection (b)(1)(A), and the Medicare Catastrophic Coverage Act, (eligibility shall be determined for a maximum of one year per determination), a hospital shall be reimbursed for disproportionate share according to the following. The mean Medicaid/MediKan inpatient utilization rate for Kansas hospitals receiving Medicaid/MediKan payments plus one standard deviation shall be subtracted from each hospital's Medicaid/MediKan inpatient utilization rate. If the remainder is greater than zero, the remainder shall be divided by 2, 2.5% shall be added, and the result shall represent the percentage payment adjustment. This percentage payment adjustment shall be multiplied by the Kansas Medicaid/MediKan annual payment for inpatient hospital services made for the state fiscal year ending two years prior to the year of the administration of a disproportionate payment adjustment. For example, 1995 state fiscal year payment adjustment shall be based upon the state fiscal year 1993 Kansas Medicaid/MediKan annual payment. The mean Medicaid/Medikan inpatient utilization rate shall include Medicare days paid by Mediciad. In order to be eligible, the hospital must have a minimum medical utilization of 1%, as determined in Option 1.

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6.2000 Option 2

Hospitals are determined to be eligible under the low-income utilization rate if, based upon the computations below, line C1 exceeds 25%. Hospitals shall be sent a form specifying the eligibility criteria prior to the start of each state fiscal year. Eligibility shall be determined for a maximum of one year per determination. Only hospitals returning the form may be potentially eligible for Option 2. This form shall be compared with the Medicare cost report (HCFA-2552-92), paid Medicaid/MediKan claims summary and other information as necessary in order to verify the data submitted.

All data below, except where specifically noted, should only include inpatient hospital data. SNF, ICF, long term care units, home health agency, swing bed, ambulance, durable medical equipment, CORF, ambulatory surgical center, hospice, or non-reimbursable cost centers shall not be considered. Although specific references are given to the Medicare cost report, other line numbers may also be applicable where the hospital uses a blank line and adds an alternative title to the forms.

A1. Medicaid/MediKan inpatient payments for the most recent available hospital fiscal year, excluding disproportionate share payments.

A2 & A3. Other state and local government income from Medicare Worksheet G-3, Governmental appropriations (Line 23), excluding Disproporitonate share payments.

A4. Total Medicaid/MediKan, State and local government funds (A1+A2+A3).

A5. Inpatient Revenues from Medicare worksheet G-2, Column 1, Total inpatient routine care services (line 16) + ancillary (line 17) + outpatient (line 18) - swing bed (lines 4 & 5) - SNF (line 6) - ICF (line 7) - LTCU (line 8).

A6. Total patient revenues from Medicare Worksheet G-2, Column 3 (line 25).

A7. Ratio of inpatient revenues to total patient revenues (A5 / A6).

A8. Contractual allowances and discounts from Medicare Worksheet G-3 (line 2).

A9. Inpatient share of contractual allowances and discounts (A7 X A8).

A10. Net inpatient revenue (A5 - A9).

A11. Ratio of Medicaid/MediKan, State and local government funds to net inpatient revenue (A4 / A10).

B1. Inpatient charity care charges, excluding Medicaid/MediKan, Medicare, contractual allowances and discounts.

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6.2000 continued

B2. Other State and local government funds (A2 + A3).

B3. Ratio of inpatient revenues to total patient revenues (A7).

B4. Inpatient portion of State and local government funds (B2 X B3).

B5. Hospital costs from Medicare worksheet B Part I, total column, subtotal (line 95) - Ambulance (line 64) - DME (lines 65 & 66) - Medicare (line 69) - unapproved teaching (line 70) - HHA (lines 71 through 81) - CORF (line 82) - HHA (lines 89 & 90) - ASC (line 92) - Hospice (line 93).

B6. Hospital revenue from Medicare worksheet G2, column 3, total patient revenue (line 25) - swing bed (lines 4 & 5) - SNF (line 6) - ICF (line 7) - LTCU (line 8) - HHA (line 19) - Ambulance (line 20) - CORF (line 21) - ASC (line 22) - Hospice (line 23).

B7. Cost to revenue ratio (B5 / B6).

B8. Hospital revenue attributable to the inpatient portion of State and local government funds (B4 / B7).

B9. Unduplicated charity care charges (B1 - B8. If this is negative, use 0).

B10. Ratio of unduplicated charity care to total inpatient revenue (B9 / A5).

C1. Low-Income utilization rate (A11 + B10).

D1. Uninsured Charges: only those patients in charity care (B1)for which no other payment is received.

Payment Adjustment

If the low-income utilization rate in C1 above exceeds 25%, then the excess over 25% shall be multiplied by 10 and the resulting number shall be multiplied by the amount of Kansas Medicaid/MediKan (excluding prior disproportionate share payments) payments for services received in the State Fiscal Year ending two years prior to the year of the administration of a disproportionate payment adjustment. For example 1993 state fiscal year payment adjustment shall be based upon state fiscal year 1991 Kansas Medicaid/MediKan annual payment.

An example of both the eligibility and payment adjustment computations are attached.

6.3000 Simultaneous Option 1 and Option 2 Eligibility

If a hospital is eligible under both 6.1000 and 6.2000, the disproportionate share payment adjustment shall be the greater of these two options.

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6.4000 Request for Review

If a hospital is not determined eligible for disproportionate share payment adjustment according to 6.1000 or 6.2000, a hospital may request in writing a review of the determination within 30 days from the notification of the final payment adjustment amount. Any data supporting the redetermination of eligibility must be provided with the written request.

6.5000 Payment Limitations

If the payments determined exceed the allotment determined by HCFA in accordance with section 1923(f)(1)(C) of the Social Security Act, then all hospitals eligible for disproportionate share shall have their disproportionate share payments reduced by an equivalent percentage which will result in an aggregate payment equal to the allotment determined by HCFA.

All hospitals are limited to no more than 100% of the cost of the uninsured plus the difference between the cost of the Kansas Medicaid inpatient services and the payments for Kansas Medicaid services. Previous years data for both the uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Kansas Medicaid inpatient costs shall be made upon receipt of an appropriate cost report.

If the hospital is a public hospital (State, city, county or district), then the payments determined above are further limited. Unless the hospital qualifies as a high DSH. Payments made during a fiscal year shall not exceed the cost incurred by a hospital for furnishing hospital services to Medicaid recipients less non DSH and to uninsured patients less patient payments. In the case of a hospital with a high disproportionate share, payments made during a fiscal year shall not exceed 100% of the amount described above. To be considered a high DSH, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or have the largest number of Medicaid inpatient days of any hospital in the State in the previous fiscal year. Previous years data for both the uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Kansas Medicaid inpatient costs shall be made upon receipt of an appropriate cost report.

Disproportionate Share Low-Income Utilization

All data on this schedule, except where specifically noted, should only include hospital inpatient data. Do not include SNF, ICF, long term care units, home health agency, swing bed, ambulance, durable medical equipment, CORF, ambulatory sugical center, hospice or non-reimbursable cost centers. Although specific line numbers from the Medicare Cost Reports are given, if blank lines on the Medicare Cost Report are used by the hospital, the blank lines should also be included or excluded, as appropriate, where there are similar references.

Hospital Name _____

Kansas Medicaid Number _____ Fiscal Year Ending _____

A1 Medicaid/Medikan inpatient payments for the most recent available hospital fiscal year, excluding disproportionate share payemnts. Contact SRS Medical Fiscal (913-296-3981) for a log summary. _____

Other State and local government income. Provide source and description. Disproportionate share payments should not be included here. (Medicare Worksheet G-3, Governmental appropriations (Line 23))

A2 _____ _____

A3 _____ _____

A4 Total Medicaid/Medikan, State and local government funds. (A1 + A2 + A3) _____

A5 Inpatient Revenues (Medicare Worksheet G-2 Column 1, Total Inpatient Routine Care Services (Line 16) + Ancillary (Line 17) + Outpatient (Line 18) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU (Line 8)) _____

A6 Total patient revenues (Medicare Worksheet G-2, Line 25, Column 3) _____

A7 Ratio of inpatient revenues to total patient revenues (A5 ÷ A6) _____

A8 Contractual Allowances and discounts (Medicare Worksheet G-3, Line 2) _____

A9 Inpatient share of contractual allowances and discounts (A7 × A8) _____

A10 Net inpatient revenue (A5 - A9) _____

A11 Ratio of Medicaid/Medikan, State and local government funds to net inpatient revenue (A4 ÷ A10) _____

B1 Inpatient charity care charges. Charity care is considered to be any unpaid charge made directly to a patient where a reasonable effort has been made to collect the charge. This would include spendown incurred by a Medicaid recipient, the deductible on insured patients, and the entire charge of private pay patients, providing a reasonable attempt to collect the amount due has been made. This should also include the portion of any sliding fee scale which is not billed to the patient. It would not include any amount billed but not paid by a third party, such as Medicaid, Medikan, Medicare, or insurance (contractual allowance) or third party or employee discounts. Information to support this number must be maintained by the hospital and is subject to review. _____

B2 Other State and local government funds (A2 + A3) _____

B3 Ratio of inpatient revenues to total patient revenues (A7) _____

B4 Inpatient portion of State and local government funds (B2 × B3) _____

B5	Hospital costs (Medicare Worksheet B Part I, Total Column, Subtotal (Line 95)) - SNF (Line 34) - ICF (Line 35) - LTCU (Line 36) - Ambulance (Line 65) - DME (Line 66 & 67) - Medicare (Line 69) - Unapproved Teaching (Line 70) - HHA (Line 71 through 81) - CORF (Line 82) - HHA (Line 89 & 90) - ASC (Line 92) - Hospice (Line 93))	
B6	Hospital revenue (Medicare Worksheet G2, Column3, Total Patient Revenue (Line 25) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU (Line 8) - HHA (Line 19) - Ambulance (Line 20) - CORF (Line 21) - ASC (Line 22) - Hospice (Line 23)	
B7	Cost to revenue ratio (B5 + B6)	
B8	Hospital revenue attributable to the inpatient portion of State and local government funds (B4 + B7)	
B9	Unduplicated charity care charges (B1 - B8 (if negative use 0))	
B10	Ratio of unduplicated charity care to total inpatient revenue (B9 + A5)	
C1	Low-Income utilization rate (A11 + B10)	
	The section below only applies if C1 exceeds 0.25. If C1 exceeds 0.25 (25%) and there is a minimum 1% Medicaid utilization, then the hospital is eligible for a disproportionate share payment as computed below (subject to verification).	
C2	Excess over 25% (C1 - 0.25)	
C3	Ten times the excess over 25% (C2 × 10)	
C4	Kansas Medicaid/Medikan inpatient payments for services rendered in the State fiscal year ending two years prior to the year of the disproportionate share payment, excluding previous disproportionate share payments. (See attached schedule)	

D1 Hospital Limitation. All hospital are limited to no more than 100% of their net Medicaid cost plus uninsured for FY 1998. The uninsured are only those patients shown in charity care (B1) for which no other payment is received. Report the uninsured here. Do not report Medicaid here. SRS shall compute the Medicaid limitation. This line must be completed by all hospitals or no disproportionate share payments will be made.

D2	Outpatient uninsured. This would be the outpatient equivalent of line D1.	
D2	Estimated disproportionate share computation (Lesser of D1+D2 adjusted to estimate the cost of services plus loss on Medicaid or C3 × C4)	

I declare that I have examined this statement, and to the best of my knowledge and belief, it is true, correct, complete, and in agreement with the books maintained by the facility. I understand that the misrepresentation or falsification of any information set forth in this statement may be prosecuted under applicable Federal and/or State law.

Signature of Officer/Administrator

Title

Date

JUN 06 2001

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

7.0000 Change of Ownership

7.1000 Department Notification and Provider Agreements

a. Each hospital shall notify the Department in writing at least 60 days prior to the effective date of the change of ownership. Failure to do so shall result in the forfeiture of rights to payment for covered services provided to recipients by the previous owner or owners in the 60 day period prior to the effective date of the change of ownership. Failure to notify the Department in writing at least 60 days prior to the effective date of the change of ownership shall result in the new owner or owners assuming responsibility for any overpayment made to the previous owner or owners before the effective date of the change of ownership. This shall not release the previous owner of responsibility for such overpayment. This notification requirement may be waived at the discretion of the Department based upon the showing of good cause by a hospital changing ownership. The new owner or owners shall submit an application to be a provider of services in the program and shall not receive reimbursement for covered services provided to recipients from the effective date of the change of ownership until the date upon which all requirements for participation pursuant to state regulations have been met or until the date upon which an application to be a provider of services in the program is received by the Department, whichever comes later.

b. At least 60 days before the dissolution of the business entity, the change of ownership of the business entity, or the sale, exchange or gift of 5% or more of the depreciable assets of the business entity, the Department shall be notified in writing. If the business entity fails to provide 60 days written notice, no reimbursement shall be made. This notification requirement may be waived at the discretion of the Department based upon the showing of good cause by a hospital changing ownership.

c. If a sole proprietor not incorporated under applicable state law transfers title and property to another party, a change of ownership shall have occurred. An application to be a provider of service shall be submitted to the Department by the new owner and affiliated providers.

d. Transfer of participating provider corporate stock shall not in itself constitute a change of ownership. Similarly, a merger of one or more corporations with the participating provider corporation surviving shall not constitute a change of ownership. A consolidation of two or more corporations which creates a new corporate entity shall constitute a change of ownership, and an application to be a provider of services shall be submitted to the Department by the new owner and affiliated providers.

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

7.1000 continued

e. Each partnership that is dissolved shall not require a new provider agreement if at least one member of the original partnership remains as the owner of the facility. Each addition or subdivision to a partnership or any change of ownership resulting in a completely new partnership shall require that an application to be a provider of services be submitted to the Department by the new owner and affiliated providers.

f. The change of or creation of a new lessee, acting as a provider of services, shall constitute a change of ownership. An application to be a provider of services shall be submitted to the Department by the new lessee and affiliated providers. If the lessee of the facility purchases the facility, the purchase shall not constitute a change in ownership.

7.2000 Certification Surveys

Each new owner or owners shall be subject to certification by Medicare.

7.3000 Cost Limitations

a. For each asset in existence on July 18, 1984, which is subsequently sold, the valuation of the asset for reimbursement purposes shall be the lesser of the allowable acquisition cost of the asset to the owner of record on July 18, 1984, or the acquisition cost of the asset to the new owner.

b. For each asset not in existence on July 18, 1984, the valuation of the asset for reimbursement purposes shall be the lesser of the acquisition cost of the asset to the first owner of record or the acquisition cost of the asset to the new owner.

c. Costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, shall not be allowable.

8.0000 Audits

The Department shall perform any reviews or audits deemed appropriate to insure the reasonableness of the cost of reimbursed services. The Department shall continue to receive information from the fiscal intermediaries of Medicare under the common audit agreement which shall identify costs incurred and which will allow for comparisons to be made to the payment which would have been made under the existing Medicare cost reporting system.